NORTHERN NEVADA ADULT MENTAL HEALTH SERVICES

POLICY AND PROCEDURE DIRECTIVE

SUBJECT: MEDICAL RECORDS – BASIC CHARTING STANDARDS

NUMBER: NN-IM-MR-20

ORIGINAL DATE: 04/03/97

REVIEW/REVISE DATE: 04/23/98, 10/02/03, 02/01/07, 2/18/10

APPROVAL: Rosalyne Reynolds *{s}*, Agency Director

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I. PURPOSE

The purpose of this policy is to delineate a method for promoting timely and accurate authenticated entries in the medical record; and to promote uniform documentation standards for Northern Nevada Adult Mental Health Services (NNAMHS).

II. POLICY

It is the policy of NNAMHS that each entry in the medical record will be uniform in format.

III. REFERENCES

1. NNAMHS Policy and Procedure #NN-IM-MR-06 entitled, “Abbreviations.”

IV. DEFINITIONS

1. EMR – Electronic Medical Record
2. CWS – Clinical Work Station
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V. PROCEDURE

A. SIGNATURES

1. Each entry in the paper record must be legibly signed with at least the first initial, full last name, and title of the staff making the entry. All electronic records will include the name/title of author, date and time of entry.
2. Rubber-stamped signatures will not be used for any entry in the medical record. Name and title may be typed on dictated reports, but the author must sign their first initial, last name, and title above the typed name.
3. All orders must be noted by a RN by writing “noted”, signature, title, date, and time.
4. All progress notes will be completed using the Clinical Workstation (CWS/Avatar). Once the progress note has been submitted, the clinician’s name, title, date and time of the entry will automatically be attached to the note.
5. Laboratory results, radiological reports, EKG’s and all other diagnostic reports must be initialed by the physician.

B. CO-SIGNATURES

1. Discharge summaries, psychiatric evaluations, and physical examinations completed by residents must be co-signed by the attending psychiatrist.
2. All physical examinations, discharge summaries, and psychiatric evaluations must be signed by the person who dictated them and by the attending psychiatrist.
3. All entries made by medical students must be co-signed by the attending psychiatrist or resident.
4. All entries by pharmacy interns must be co-signed by a licensed pharmacist.
5. In the EMR inpatient chart only, all entries by unlicensed persons, including students and interns, must be co-signed by a licensed staff of

that discipline. Inpatient MHT entries are exempt.

6. Residents may co-sign for medical students only and may not sign for another resident or in lieu of the attending physician
7. Entries by social work or psychology interns must be co-signed by a licensed LCSW/psychologist.

C. DATE AND TIME

1. Each entry in the medical record must state the date and time of the entry.
2. The physician must sign all telephone orders and state the date and time of his/her signature.
3. While the patient is a current inpatient or outpatient, written information received from outside sources must be dated by the person who receives it prior to placing it in the paper medical record.
4. Written information received from any source after discharge will be dated by H.I.S. prior to being placed in the paper medical record.

D. LATE NOTES

Late notes must be identified in the EMR by typing “LATE ENTRY” for and the date and time of actual service at the beginning of the progress note.

E. ERRORS

1. To avoid errors, verify the name on the consumer’s paper chart and the EMR
2. Errors occurring using the EMR must be reported to the IT Department who will make the necessary corrections.
3. In the paper medical record, errors must be corrected by drawing one line through the erroneous portion, writing the word “error” next to it, signing with first initial, last name, and title, dating, and timing the error.

EXAMPLE:

~~He was angry that police were called by his mother.~~

Error J. Jones, RN 2/10/96 0800

F. DICTATED MATERIAL

1. Material that is dictated and typed for the medical record must be signed by the author of the entry as soon as possible after its entry into the record.
2. Dictated material must be identified by the typed initials of the author, transcriptions, date dictated, and date transcribed.

EXAMPLE: BL/la

D: 02/10/96

T: 02/10/96

G. SIGNING FOR ANOTHER AUTHOR

1. Residents, medical students, and interns shall not sign in lieu of each other or any other physician.
2. Physicians may sign in lieu of other physicians if they were involved in the care of the consumer.
3. A physician serving as the Medical Director or designee may sign in lieu of any physician, resident, or medical student.
4. A physician serving as the Chief of Staff or designee may sign in lieu of any physician, resident, or medical student

H. OTHER

1. All handwriting must be legible.
2. The consumer's social security number will not be included in or on clinical forms/documentation.
3. All entries in the paper medical record must be typed or handwritten in black ballpoint ink. Other colored ink, felt-tip pens, gel pens and pencils are not to be used in the paper medical record
4. Each page in the paper medical record must have the consumer's name and medical record number written in the designated space. If both sides of a page are used for documentation, the consumer's name and medical record number must be written on both sides.

5. All items on pre-printed forms must be addressed; no items may be left blank. If the consumer was not seen or refuses to cooperate, a diagonal line may be drawn through the page and a statement made as to why the form could not be completed. This statement must be signed, dated and timed.
6. IP/POU admission/discharge orders must be signed by a staff physician (co-signatures for residents are accepted.)
7. The DAP (Data or Description, Assessment, Plan) format must be used on all progress notes.

   EXAMPLE:

DATE/TIME	DISC.	PROBLEM #	PROGRESS NOTES
2/10/96	RN	2	D A
1700			P

   Do not insert an “A” or “P” in the middle of a line. Begin each “A” section and each “P” section at the far left of the line, as shown in the sample above.

7. Orders cannot be rescinded. They must be cancelled.
8. When referring to the consumer in their record, the consumer may be referred to by name.
9. When mentioning other consumers, visitors, family members, etc., do not identify the person by name, initial, or number. They may be identified by “male peer,” “mother,” “female friend,” etc.
10. Notes may not be written in the margins of any document in the paper medical record.
11. Notes may not be written below the last line on a form in the paper medical record
12. Entries in the medical record must not be used to settle disputes; denigrate

consumers, staff or organizations; or assign blame.

13. Reference to incident reports is not to be made in the medical record. The event, action taken, and the consumers condition following the event must be described in the progress note. Incident reports are not to be filed in the medical record.
14. NNAMHS staff and contract staff will not use banned abbreviations when documenting in the medical record. See NNAMHS Policy #NN-IM-MR-06
15. Entries in the record should communicate respect for the consumer at all times.
16. For each bill generated from a service provided, there must be a corresponding progress note completed by the clinician describing in detail, the billable service.